MEDICARE AND MEDICAID CONTRACTING

Report to the Administrator
Health Care Financing Administration
Department of Health, Education and Welfare

Volume I

Recommendations

October 31, 1978

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
WASHINGTON, D.C. 20201

OFFICE OF THE ADMINISTRATOR

October 31, 1978

Mr. Robert A. Derzon
Administrator
Health Care Financing Administration
330 C Street, SW
Washington, D.C. 20201

Dear Bob:

I am pleased to submit the final report of the Steering Group which you appointed to study the administration of the Medicare and Medicaid programs. The Steering Group has spent nine months carefully examining and discussing the many options which surround the issues of Medicare and Medicaid contracting in arriving at its recommendations. These recommendations call for enactment of legislation to allow for a major restructuring of the administration of the Medicare program by combining and fully integrating Part A and Part B under a single contractor. The recommendations for Medicaid, however, call for improving procurement practices and can be implemented administratively. The experiments which the Steering Group is recommending to integrate the administration of Titles XVIII and XIX and to separate the provider reimbursement and audit function can be conducted under existing authorities.

We hope that the Health Care Financing Administration will carefully weigh these recommendations and proceed with implementation in the near future. The Steering Group strongly believes that implementation of these recommendations is necessary for the efficient and effective operation of the Medicare and Medicaid programs and that they will provide the basis for any future program changes especially with respect to a national health insurance program.

Sincerely yours,

Gene Rubel

Eugene J. Rubel
Chairman of the Steering Group

Volume I: Recommendations

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I. INTRODUCTION

This report discusses recommended changes in the administration of the Medicare and Medicaid programs in order to enhance coordination, improve program management, contain administrative and program costs, and promote effective delivery of services to providers and beneficiaries. This report is the result of a nine month study requested by the Administrator of the Health Care Financing Administration (HCFA) to examine the methods for selecting, monitoring and reimbursing contractors under the Medicare and Medicaid programs. The study was conducted by a Steering Group established by the Administrator, HCFA and consisted of high level administrators within the Department of Health, Education and Welfare (see Appendix 1). The Directors, senior management and technical staffs of the Medicare and Medicaid programs were also extensively involved in the study and played an active role in providing background information and input to the issue papers from which the recommendations were made. The recommendations represent the consensus of the Steering Group.

This report consists of two volumes. The recommendations of the Steering Group regarding changes in the administrative structure of the Medicare program and the contracting processes of the Medicaid program are contained in Volume I following this introduction. A complete discussion of the Medicare and Medicaid issues including various options, the advantages and disadvantages of each option, cost savings, and administrative, legislative, budgetary, social and political constraints is contained in Volume II.

II. CONCLUSIONS AND RECOMMENDATIONS

The following recommendations for change stem from the existing program structure and statutory base of the Medicare and Medicaid programs. They are based on the premise that the Federal Government and the States will continue to rely on the private sector in administering all or part of the Medicare and Medicaid programs. Thus, they should be reexamined if the current program structures or statutory bases are modified.

These recommendations reflect the careful and considered judgments of the Steering Group and were arrived at only after an in depth examination and discussion of the many options surrounding the issues of Medicare and Medicaid contracting. Since its inception, the Medicare program has been operating fairly smoothly with its existing administrative structure. Only after many agonizing deliberations did the Steering Group finally determine that it was time to make changes in the administration of the Medicare program. The Medicaid program, on the other hand, has experienced severe problems for many years. The Steering Group believes it is time to initiate action to address and eliminate these specific problems.

The Steering Group recommends:

. HCFA seek new legislation to permit a combined and fully integrated Part A and Part B structure for administration of the Medicare program. In combining the administration of Part A and Part B, the number of contractors should be reduced, the contractor areas should be defined on a geographic basis using States as the building block, the nomination process should be eliminated, the prime contract with the Blue Cross Association should be terminated, and the role of the Division of Direct Reimbursement should be limited to dealing only with Federal providers and special cases where the Government believes it is advantageous to efficient program administration. In addition, all contractors should be selected on a competitive basis and should not be limited to insuring organizations or to organizations currently serving as contractors. Contractors should be reimbursed on a fixed price or fixed rate basis rather than on a cost basis. Implementation of these recommendations would be phased in over a period of time to ensure a very effective transition to the new contracting mode and to assure no disruption to Medicare operations. Furthermore, HCFA should experiment with separating the provider reimbursement and audit function from other contractor functions under a combined Part A and Part B arrangement.

- If a decision is made not to combine the administration of Medicare Part A and Part B under a single contractor, legislation should be sought to eliminate the nomination process under Part A and to select and reimburse intermediaries on a competitive fixed price or fixed rate basis. In addition, the number of intermediaries should be reduced by redefining intermediary jurisdictions based on geography with State boundaries as the building block, but not to exceed an HEW region. Furthermore, the Blue Cross Association prime contract should be terminated and the role of the Division of Direct Reimbursement should be limited to dealing only with Federal providers and special cases where the Government believes it is advantageous to efficient program administration. HCFA should also experiment with separating the provider reimbursement and audit function from other functions performed by intermediaries. For Part B, carrier jurisdictions should be redefined based on geographic and workload characteristics using State boundaries as a building block to allow for multistate or substate areas and the number of areas should be reduced. In addition, legislation should be sought to select and reimburse carriers on a competitive fixed price or fixed rate basis and should not be limited to insuring organizations.

- HCFA should conduct experiments with respect to integrating the administration of the Medicare and Medicaid programs under a single contractor. These experiments can be conducted under existing statutory authorities.

- HCFA should impose substantive requirements and mechanisms to improve, monitor and evaluate State procurement practices to ensure effective competition for contracts in the Medicaid program. Additionally, policies should be standardized, wherever possible, to institute uniformity between Medicare and Medicaid contracts and contracting procedures. These actions can be implemented on an administrative basis and do not require enabling legislation.

III. MEDICARE

A. Background

The Medicare program is a Federal health insurance program for persons 55 years of age or over, and for disabled beneficiaries and persons with chronic renal disorders. The program was established by Congress in 1965, when it enacted Title XVIII of the Social Security Act. The Medicare program consists of two distinct parts. Hospital Insurance, or Part A of the program, covers expenses of medical services furnished in an institutional setting, such as a hospital or skilled nursing facility (SNF), or provided by a home health agency (HHA). Medical Insurance, or Part B of the program, covers physician services, certain other medical equipment and services, and other outpatient services.

In order to insure a quick and smooth implementation of the Medicare program in 1965, Congress adopted as part of the Act an administrative structure which was compatible with the historical pattern of administration used by the private health insurance industry. The Federal Government contracts with public or private organizations to facilitate payments to providers of services and beneficiaries. These organizations are known as intermediaries under Part A and carriers under Part B.

Medicare intermediaries and carriers perform the same functions in the adjudication of claims (e.g. claims review and processing, utilization review, beneficiary hearings and appeals, etc.) and provide similar support services such as professional relations, and financial accounting and statistical activities. The one contractor function which is unique to the intermediary is that of provider reimbursement and audit. Provider reimbursement activities include establishment, review and revision of interim reimbursement rates and periodic interim payments, recoupment of overpayments, and consultant services to providers in establishing and maintaining provider accounting systems. Provider audit includes auditing, final cost settlements, and appeals as they relate to settlements.

Medicare intermediaries and carriers are reimbursed for their administrative costs under the basic principle of no profit and no loss. These contractors are not at risk with respect to program benefit payments as these payments are entirely underwritten by the Federal Government.

The original Medicare legislation provided two methods for the selection of contractors. In selecting carriers under Part B

the Department had the authority to enter into contracts with private and public insurance companies to handle physician services. Carriers were selected by the Department and assigned to serve specific geographic areas as determined by the Department. The Department was exempt from any competitive bidding requirements in selecting carriers. Initial carrier selections were based on the insurance company's 1965 experience in health care reimbursement and its financial stability. Currently, there are 46 carriers servicing 60 geographical areas.

The method of selection of intermediaries under Part A is through a nomination process whereby hospitals, skilled nursing facilities, home health agencies and other providers may nominate an organization through whom they wish to deal with the Government or they may elect to deal directly with the Government. Upon notice to the Department, a provider may change its intermediary; thus, the provider has the flexibility to "shop" for an intermediary that meets its needs. The Government initially could not require providers to use a particular intermediary, since to do so would violate the providers' rights under the nomination provision.

The enactment of Public Law 95-142 in 1977 increased the Department's authority with respect to the nomination and termination process. Section 14 of Public Law 95-142 amends Section 1816 of the Social Security Act and authorizes the Department to assign and reassign providers to available intermediaries, and to use regional and national intermediaries for a single class of providers (e.g. hospitals) when it is in the best interest of effective and efficient program administration. Thus, the provider might not be serviced by the intermediary which it originally nominated. Where a provider is assigned to another intermediary, the intermediary does have the right to appeal.

As a result of the original nomination process, the Blue Cross Association (BCA) was selected as fiscal intermediary by the bulk of hospitals and by substantial numbers of skilled nursing facilities and home health agencies seeking participation in the program. A prime contract was awarded to BCA which in turn subcontracted with its local Blue Cross Plans around the country to perform the actual functions required of an intermediary. At that time, the prime contract appeared to be a useful tool in implementing and gaining acceptance of the Medicare program. The remaining provider groups and other individual providers nominated commercial insurance companies or the Government. Currently, there are 77 intermediaries.

Those providers which elect to deal directly with the Government are serviced by the Division of Direct Reimbursement (DDR) in the Medicare Bureau. DDR services a variety of providers including:

243 hospitals
410 emergency providers (405 Federal and 5 non-Federal)
6 chronic renal disease facilities
16 migrant hospitals
32 Kaiser providers
86 skilled nursing facilities
17 physicial therapy providers
384 home health agencies
160 comprehensive health centers

1354 - TOTAL

These providers are located in 45 States, the District of Columbia and Puerto Rico.

DDR services these particular providers for various reasons. In some cases the providers were declined by the nominated intermediary. In other cases the provider did not wish to deal with the private sector or was dissatisfied with its previous intermediary. For Federal providers, using DDR was the simplest method of reimbursement. Some providers such as the migrant hospitals are part of experiments.

Contracts entered into under Part A and Part B provide for termination or nonrenewal upon appropriate notice by either party. Under Part A the Department may also terminate the contract at any time, if it finds that the intermediary has failed substantially to carry out the agreement, or that the continuation of some or all of the functions by the intermediary is disadvantageous or inconsistent with efficient administration of the program. Under Part B, the Department must make such a finding only if it terminates the contract at any time for cause. These prime contracts with intermediaries and carriers are for one year terms and are automatically renewable unless notice is given by either party.

As previously mentioned, the administrative structure under which the Medicare program operates was originally adopted to insure a smooth and timely acceptance and implementation of the program. Providers were afforded an opportunity to actively participate in program implementation through the nomination process. The private health insurance industry became active participants in performing intermediary and carrier functions. The noncompetitive approach to selecting contractors and awarding

contracts and the reimbursement of all reasonable costs provided an incentive to private and public insuring organizations to participate since any risk was minimized. This contracting approach was also convenient to the Government since it minimized the time and expense normally associated with competitive contracting.

This administrative structure has worked extremely well in providing a smooth operation of the Medicare program over the past 12 years. Only a small number of providers and contractors have dropped out due to dissatisfaction with the program. The reimbursement of contractors on a cost basis has provided the Government great flexibility in making program changes without opposition or decrease in performance on the part of the contractor since all new costs are reimbursable. Renewal of contracts with the same organizations year after year has provided continuity in the program and promoted effective working relationships between the contractors and providers and beneficiaries.

B. Current Operating Problems

Over the years, there have been significant changes in the industry--in technology, in the organization, and in program acceptance. Thus, the initial administrative structure which addressed original program needs may no longer be appropriate in today's environment.

The carrier geographic configuration determined by the Secretary in 1965 evolved without the benefit of program experience. As a result, carrier workloads under Part B are unevenly distributed which creates operational inefficiencies. The variance in workload affects the cost of operations since high volume carriers tend to have low unit costs and low volume carriers have high unit costs. For example, in fiscal year 1977, California Blue Shield processed 9,132,210 claims at a unit cost of $2.53 while South Dakota Blue Shield processed 221,906 claims at $3.93 per claim.

Under Part A, the nomination process restricted the Department's authority for determining intermediary jurisdictions. The opportunity for providers to nominate and change intermediaries at any time causes the size and location of intermediary jurisdictions and workloads to fluctuate. Although such change has been minimal, it is costly to the Government since an intermediary needs to enlarge or scale down its operations to accommodate the change in workload. The nomination process also results in the overlapping of intermediary jurisdictions which can cause the inconsistent application of program policies to providers in the same geographic area. For example, Blue Cross,

Aetna, Mutual of Omaha, Kaiser and Nationwide all perform an intermediary function to the providers in Ohio. The remote geographic dispersion of providers using the same intermediary sometimes results in ineffective communications between the parties and untimely delays in processing bills due to the long distances involved. This is a problem for multistate intermediaries, particularly DDR which services providers in 45 States, the District of Columbia and Puerto Rico from its Baltimore, Maryland office.

In many cases the same organization functions as both an intermediary and a carrier (e.g. Prudential Insurance) but maintains separate inhouse operations for each part of the program. This may cause costly and duplicative monitoring for the Government and create inefficient administration for the contractor. In cases where the intermediary and carrier in a specific geographic location are different, the beneficiary is adversely impacted in having to deal with two different organizations for its Medicare benefits. Utilization review also becomes more difficult.

Reimbursing contractors on a cost basis has discouraged efficiencies in the program, although it has provided the Government with flexibility in managing the program. Since contractors are not at risk for cost there is no strong incentive to be economical in performing their functions. Thus, administrative costs of the Medicare program have increased over the years to the extent that Congress enacted legislation in 1972 to permit the Medicare program to experiment with different approaches to reimbursing contractors. The Medicare program is currently conducting three experiments with carriers to reimburse other than on a cost basis. These experiments include a negotiated fixed rate contract with Maryland Blue Shield, a fixed price contract with Massachusetts Blue Shield to administer the Part B program in the State of Maine, and a fixed price contract with Electronic Data Systems Federal (EDSF) to administer the Part B program in Illinois. The EDSF contract also consolidated the existing two-carrier jurisdiction into one. A fourth contract which consolidates three carrier jurisdictions into one in upstate New York will be awarded on a fixed price basis in the near future.

C. Recommended Actions

Combine Administration of Part A and Part B

In light of the existing inefficiencies in the administration of the Medicare program and the current climate for cost containment

and new initiatives for effective program management, it is recommended that the administration of Medicare Part A and Part B be combined into a totally integrated structure along functional lines. The initial separation of Part A and Part B was an accident of the legislative development of the Medicare program and if the Medicare law was to be written today, it is unlikely such a split would occur. Today there are many crossovers between the two parts of the program such as home health benefits under both programs, or hospital outpatient services handled by Part A intermediaries, but considered a Part B benefit. In combining the administration of Part A and Part B the nomination process would be eliminated to permit the defining of contractor jurisdictions which promote efficient operation of the program. These contractor jurisdictions would be based on optimum workload using State boundaries as the building block. Thus, depending on workload size, a contractor might service a single State, a multistate or a substate area. Using State boundaries as a parameter for contractor jurisdictions would facilitate any future integration of the Medicare and Medicaid programs. This approach would also provide for a more equitable distribution of work and maximize the potential for cost savings through the economies of large scale operations resulting from combined workloads.

Combining the administration of Part A and Part B under a single contractor based on State configurations would decrease the number of Medicare contractors and thereby reduce total administrative costs. Cost savings would be realized by eliminating duplicative hardware systems, software systems, physical plants and administrative structures. Additional cost savings would be achieved through better utilization review and control of program payments resulting from the establishment of single beneficiary data bases.

Integration of Part A and Part B under a single contractor would provide better coordination and flow of information on program activity and improve exchange of data with Professional Standard Review Organizations (PSROs), Medicaid and other agencies. The interrelationships between providers in a geographic area through common ownership or arrangements for services could be more closely examined and their impact on the program assessed. Integration would also achieve more uniform and consistent application of program policies and procedures with respect to the provider community and beneficiary population. Furthermore, it would provide a basis for any future integration with the Medicaid program.

Combining the administration of Part A and Part B under a single contractor would also improve the relationship of the Medicare program to its beneficiaries because it would provide a single contact point. Beneficiaries are often confused because they have difficulty understanding why they need to deal with one organization for

hospital benefits and another organization for their doctor bills. Integration would promote more effective communication and service with the beneficiary community.

Overall, integration of Part A and Part B would provide for greater effectiveness and consistency in program administration and considerably enhance the Medicare program's capability to accommodate and implement legislative changes in the future.

Elimination of the nomination process which is required to facilitate integration of Part A and Part B under a single contractor would also provide the basis for elimination of the Blue Cross Association prime contract and would eliminate the statutory basis for the existence of the Division of Direct Reimbursement. The elimination of the BCA prime contract is significant because it was originally negotiated to implement and gain acceptance of the Medicare program in 1965 and has since outlived its usefulness. Over the years decentralization of the Medicare program through its regional offices has provided the framework for direct relations between the regions and the individual Blue Cross plans. This decentralization was implemented to achieve more effective program administration. The major responsibilities for monitoring of plan activities and performance, and the negotiation and settlement of plan administrative budgets has shifted from an interrelationship between BCA and the Medicare Bureau central office to the regional office and local Blue Cross plans. BCA's role is now primarily a link or pass through deriving from the nature of the nomination process. If the nomination process is not eliminated, it is still recommended that the Blue Cross Association prime contract be terminated and steps taken to contract directly with local plans.

The Division of Direct Reimbursement, on the other hand, should not be totally eliminated but should play a specialized role in the administration of the Medicare program. DDR would handle only Federal providers since all Federal providers are presently tied into DDR for reimbursement and do not conveniently fit into the private sector. DDR would also be available for use in selected experiments. Using DDR in experiments allows the Government to test new policies and procedures with the advantage of direct input and feedback without major disruption to day to day operations.

Selection of Contractors on a Competitive Basis

The selection of contractors under an integrated approach would be on a competitive basis and not be limited to insuring organizations or to organizations currently serving as Medicare contractors. Contractors would be reimbursed according to a fixed price or fixed rate rather than cost. Selecting contractors on a competitive basis would stimulate potential contractors to increase the efficiency of their operation and thus reduce costs in order to submit the lowest possible bid

to win the contract. Competing contracts periodically as opposed to renewing them yearly for an indefinite period of time would stimulate competition and encourage contractors to improve performance. It would eliminate the complacency which exists in the current contractor community. Switching to a competitive selection process would also provide the Medicare program an opportunity to terminate marginal contractors who have been performing at lower levels.

It is recognized that periodic competition will lead to a change in contractor in many cases. This change may cause inconvenience to providers and beneficiaries who will have to become acquainted with the new organization. In addition, it will require funding for start up and phase out of contractors. Employees of existing contractors may be impacted. Nevertheless, on balance, the Steering Group believes that the benefits resulting from competition outweigh these disadvantages and recommends that periodic competition be required.

Pay Contractors on a Fixed Price or Fixed Rate Basis

Fixed price or fixed rate contracts provide for the Government to pay a fixed dollar amount for specific services. This fixed dollar amount is not adjusted for cost overruns or underruns. Thus, unlike cost reimbursement contracts which involve no risk, fixed price/fixed rate contracts involve risk to the contractor but also have the potential for profits. Fixed price and fixed rate contracts also provide the greatest incentives to increase efficiency, promote systems enhancements, stimulate and invite management and technological innovations and decrease administrative costs. These contracts also minimize the need for governmental interference in the day-to-day management of the contractor's operations. Government control is exercised through assessment of liquidated damages if products are of poor quality or services do not meet specified standards. In addition, fixed price and fixed rate contracts lend themselves easily to open competition and encourage firms with competence and capabilities to compete.

It is recognized that the possibility exists for program costs to increase under a fixed price arrangement since a contractor would have the incentive to process all claims quickly and minimize its expenditure of resources. The Steering Group does not believe this will occur because 1) contractor functions will be clearly and specifically detailed in the contracts, 2) the contracts will be carefully and closely monitored and, 3) an intensive quality assurance program with sufficient performance standards will be implemented to insure good performance and service by the contractor.

Conduct Experiments Relating to the Provider Reimbursement and Audit Function

An issue related to combining and functionally integrating Medicare Part A and Part B under a single contractor is whether the provider reimbursement and audit function, due to its uniqueness, should be included under the single contract or contracted for separately. Separating the provider reimbursement and audit function from claims adjudication and support services has many advantages. Separate contracts could reduce conflict of interest by creating a system of checks and balances through the use of two contractors. Separating the functions would also promote economies of scale by permitting potential contractors to specialize in one function. It would expand the contractor market since non-health insuring organizations could be awarded contracts for the provider reimbursement and audit function (e.g. independent accounting firms). Moreover, it would facilitate termination of either contract with less impact on the other contracted functions(s). Separation of the provider reimbursement and audit function would also provide a base for adopting future program changes such as prospective rate reimbursement and for integration of Medicare and Medicaid.

On the other hand, awarding of separate contracts for claims adjudication and support services, and provider reimbursement and audit may increase the total number of contractors and thus increase total administrative costs. Such a separation would break the established relationships between intermediaries and providers even in their private lines of business and cause major problems in program operations by dividing responsibility and accountability for program performance between the two contractors. Lack of efficient and effective communications links between the two contractors handling the separate functions would also impede smooth operations. Furthermore, HCFA would need to make changes in its monitoring and evaluation procedures, develop staff expertise, and modify its administrative structure.

Since historical information relative to this issue is almost nonexistent, it is recommended that HCFA conduct an experiment to examine the problems and study the effects of separating the provider reimbursement and audit functions from other contractor functions before making any policy decisions on this issue.

Changes in Part A

If a decision is made not to combine the administration of Medicare Part A and Part B under a single contractor, it is still recommended that legislation be sought to eliminate the nomination process under Part A and to select and reimburse intermediaries on a competitive fixed price or fixed rate basis in order to promote efficiency and

increase the effectiveness of the program. The number of intermediaries should be reduced by redefining intermediary jurisdictions based on geography with State boundaries as the building block for intermediary configurations. One intermediary would serve all providers in a defined area.

This approach would provide the opportunity to apply all program requirements consistently to all providers in the area. The entire provider and beneficiary community would look to a single Medicare intermediary and thus provider and beneficiary services in the area should be enhanced. The interrelationships between providers in an area through common ownership or arrangements for services and the whole range of clinics, SNFs, and HHAs which are hospital based or related, can be more effectively addressed. Utilization controls and relationships with PSROs and State agencies can also be more effectively carried out. Audit and reimbursement functions would be enhanced since multiple audit capabilities and interpretations from different intermediaries in the area would be eliminated. This approach should also provide a sufficient number of the different types of providers in most cases to give the single intermediary the depth of operating experience and expert knowledge of technical policy to effectively service the different classes of providers and their unique problems. Application of Section 223 limits and other special provisions dealing with cost containment should be more easily and effectively carried out. This geographic approach should permit a more intensive effort in communicating and interpreting program policy and requirements to the provider community and the beneficiary population. Special emphases and program initiatives and changes could be more effectively communicated and implemented. Under a State configuration, program savings may range from 5 to 10 percent of total administrative costs.

Furthermore, the Blue Cross Association prime contract should be terminated and the role of the Division of Direct Reimbursement should be limited to dealing only with Federal providers and for use in selected experiments for reasons previously discussed. In addition, experiments should be conducted to test the impact of separating the provider reimbursement and audit function from other intermediary functions.

Changes in Part B

For Part B, it is recommended that carrier jurisdictions also be redefined based on geographic and workload characteristics using State boundaries as a building block to allow for multistate or substate areas. Carrier territories would be of optimum size to allow for economies associated with large scale operations, thus reducing the number of carriers. In addition, legislation should be sought to select and reimburse carriers on a competitive fixed price or fixed rate basis and not limit them to insuring organizations.

IV. MEDICAID

A. Background

The Medicaid program is a voluntary Federal grant-in-aid program under which States may enter into agreements with the Secretary to finance health care services for public assistance recipients and other low income individuals and families. The program was established in 1965 when Congress enacted Title XIX of the Social Security Act and succeeded earlier welfare-linked medical care programs, most notably the Kerr-Mills program of medical assistance for the aged.

Title XIX requires that certain basic services must be offered in any State Medicaid program: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, skilled nursing facility services for individuals 21 and older, home health care services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services, and early, periodic screening, diagnosis and treatment (EPSDT) for children. In addition, States may provide a number of other services, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, dental care, etc.

States determine the scope of services offered and the reimbursement rate for these services subject to Federal guidelines. They also exercise a great amount of control over the income eligibility levels for Medicaid. All of these variations--in benefits offered, groups covered, income standards and levels of reimbursement for providers--mean that Medicaid programs differ greatly from State to State.

If a State chooses to participate in the Medicaid program, it must develop a State Plan for the program as specified in Section 1902 of the Act. The Secretary must approve any plan which meets the conditions in the Act. The Secretary may not terminate an agreement with the State but it can withhold Federal matching funds and impose penalties if the State is not in compliance with its State Plan or if its State Plan is changed and no longer meets the conditions of the Act. Currently, all States, except Arizona, plus the District of Columbia, Puerto Rico, Guam and the Virgin Islands participate in the Medicaid program.

Under Section 1903, the Secretary is authorized to pay each State which has an approved plan, a matching of medical services costs at a rate based on each State's per capita income. It also

matches State administrative costs, which can vary by administrative function. For example, Public Law 92-603, Section 235 amended Section 1903 and authorized the Secretary to match up to 90% of the costs for the design, development or installation of approved mechanized claims processing and information retrieval systems and up to 75% for the operation of such systems. These systems are known as Medicaid Management Information Systems (MMIS). In developing and operating its MMIS a State may contract with another organization to perform certain functions.

States are ultimately responsible for their Medicaid programs. Some States administer their Medicaid programs directly (inhouse), while others contract with the private sector to perform various functions of programs either through health insuring agreements or fiscal agent contracts. Under insuring agreements, the contractor is responsible for paying all valid claims for covered services received by eligible persons in exchange for a predetermined per capita premium. Health insurance agreements involve high risk and few States use them. Currently, only four States use insuring agreements for some of their specialized services (e.g. durgs).

Fiscal agent contracts are currently used by 35 States to process and pay vendor claims for some or all services. In 1965, at the beginning of the Medicaid program, fiscal agent contracts were limited in number and type of service covered. As Medicaid services and expenditures grew, more contracts were used since most States did not have sophisticated inhouse systems to accommodate these changes. The simultaneous implementation of Medicare, with its reliance on contractors, encouraged some States to abandon their inhouse arrangements in favor of using Medicare contractors who they believed had efficient and sophisticated systems. They also felt that duplicative claims processing efforts would be eliminated. Fiscal agents are reimbursed on either a cost reimbursement or fixed price or fixed rate basis. Each fiscal agent contract is unique and varies as to types of claims covered, reimbursement methodology, duration of contract. In some instances, a State fiscal agent may subcontract a portion of its function to another organization. Fiscal agent contracts account for approximately 46% of the total Medicaid claims processing workload.

B. Current Operating Problems

Federal requirements which focus on Medicaid contracts and contract procurement have been minimal since Federal policy has been to leave such administrative matters to the States. The first set of regulations pertaining to contracts for health

insurers and fiscal agents were not issued until 1971 when the Federal Government sought to gain control over the rapid expansion of Medicaid program expenditures including those administered through contracts. These and subsequent regulations, however, are general in nature and do not require that the Medicaid Bureau become actively involved in contract development and award. Current regulations require States only to submit all planned expenditures greater than $100,000 for fiscal agent or health insuring contracts to the Department for prior written approval as a condition of receiving Federal matching. States may use their own procurement policies in lieu of Federal procurement regulations, subject only to the general admonition that they provide for free and open competition. In addition, OMB Circular A-102, Uniform Administrative Requirements for Grants-In-Aid to State and Local Government--Attachment O, Procurement Standards, states that "no additional (procurement) requirements shall be imposed by the Federal agencies upon the grantee unless specifically required by Federal law or executive order." Until recently, the Medicaid Bureau has interpreted OMB Circular A-102 as well as other regulatory requirements as barring an active Federal role in State procurement activities. Thus, the Federal Government has participated in State procurement activities only when and to the extent requested by the States.

In contrast, the Medicaid Bureau was able to implement specific regulations pertaining to the development and operation of MMIS systems which require prior review and approval of all procurement documents, not just the final contract. States which enter into "combination" contracts (fiscal agent plus MMIS system operation) are subject to MMIS regulations requiring prior review and approval.

Minimal Federal involvement in State Medicaid procurement activities has resulted in a patchwork of highly generalized and ineffective State procurement processes which fail to meet the special needs of the Medicaid program. The dearth of State expertise in contracting as well as the current void in definitive Federal policy and guidance have led to increasing confusion and the reluctance of many capable organizations in the private sector to become involved in contracting with the Medicaid program.

Some of the recent contracting problems encountered in State procurements which restrict free and open competition and which seriously reflect the void of current Federal regulatory and managerial safeguards include:

- insufficiently publicizing the intent to contract
- inserting requirements into the Request for Proposal (RFP) which only one organization could meet
- changing the RFP after it has been circulated to prospective contractors when the change places a particular organization in a preferred position
- providing inadequate program information and data to potential contractors, thereby placing the incumbent in an advantageous position
- non-uniform evaluation of proposals based on a desire to award a contract to a particular organization
- awarding contracts on a sole-source basis
- renewing contracts yearly rather than recompeting each time.

Such practices have resulted in contracts which are disadvantageous to the Federal Government and have consequently increased program costs.

Recently, as a result of Government Accounting Office (GAO) investigations, increased congressional interest in Medicaid administration, and the creation of the Health Care Financing Administration, the Medicaid program has begun to play a more active role in the State procurement process and to initiate certain steps to meet the growing demands and problems in State procurements. These steps include:

- forcing changes in State contracting procedures through the threat of denied Federal matching on a State-by-State basis
- issuing voluntary procedures for States to follow in making procurement awards which include prior Federal review and approval of State procurement plans, requests for proposals, evaluation criteria and proposed contracts
- requesting an exception to OMB Circular A-102.

Despite these initial efforts, the Federal involvement in State procurement activities is still proceeding on a case-by-case basis. There is presently no regularized or coherent mechanism at the Federal level for the administration and control of contracts under the Medicaid program.

C. Recommended Actions

In order to promote fair and open competition for Medicaid procurements as well as assure the proper and efficient administration of State contracts, it is recommended that the following be developed:

- a mechanism to generate, evaluate and monitor a coherent national picture and understanding of State procurement practices
- an overall program strategy for contract administration under Medicaid
- comprehensive policies and regulations to guide State procurement processes
- detailed procedures to provide effective oversight and monitoring of procurements

Implementation of this recommendation does not require any new legislation and can be achieved administratively especially if a waiver to OMB Circular A-102 is granted by the Office of Management and Budget. If a waiver is not granted then statutory changes should be sought. The Steering Group views this set of recommendations as absolutely essential in the management of the Medicaid program. Implementation of this recommendation should be among the highest priorities of the Health Care Financing Administration.

V. MEDICARE AND MEDICAID

A. Integration

As previously mentioned, the Medicare program is a Federal health insurance program for people 65 years of age and over, disabled beneficiaries and persons with chronic renal disorders, while the Medicaid program is a State-administered Federal grant-in-aid program for medical assistance to certain low-income individuals and families. The programs differ in eligibility, benefits provided and reimbursement. Expenditure of program dollars is controlled by the Federal Government under Medicare and by the States under Medicaid. Both programs have been operating for approximately the same period of time although Medicare has operated smoothly while Medicaid has experienced severe problems.

A substantial number of beneficiaries (approximately 4 million), however, are eligible for both programs. In addition, the provider community is basically the same for Medicare and Medicaid. Both groups, however, must deal with two separate programs with different procedures and rules. This is cumbersome for the beneficiaries and providers and costly for the Government.

The Medicare and Medicaid programs both use contractors in administering their programs. These contractors usually perform the same basic functions relating to benefits, claims processing, reimbursement, utilization review, fraud and abuse control, and beneficiary and provider relations. In many cases the contractor is the same for both programs but maintains separate inhouse operations--one for Medicare and one for Medicaid.

It appears that combining the administration of the Medicare and Medicaid programs under a single contractor and integrating the hardware systems, software systems, physical plants and administrative structures could eliminate duplication, reduce administrative complexity, achieve more consistent application of policy, encourage more effective communication and service to beneficiaries and providers, and promote cost savings. Cost savings, both program and administrative, may be obtainable through economies associated with large scale operations, elimination of duplicative billings and payments, closer monitoring of provider allocation of costs, common audits, more uniform cost settlements, and establishment of single profiles for providers and beneficiaries for greater detection of fraud and abuse.

Although it appears that integrating the administration of Medicare and Medicaid could produce cost savings, the approach may not be viable. It is recommended therefore, that HCFA conduct

experiments to test the feasibility and impact of combining the administration of the two programs. The findings of the experiments would determine whether integration should be pursued on a national basis. If the findings indicate that integration is cost effective and feasible, the administrative procedures and operational techniques necessary for nationwide implementation will have been developed and tested during the course of the experiment. If integration does not appear cost effective or feasible, the approach can be easily abandoned without major disruption to the operating programs. Experimentation also provides the opportunity to test different integration models before becoming nationally committed to a particular approach. Different types of models which might be considered include:

- the State Medicaid program and the Medicare program would each contract separately with the same contractor to operate an integrated system

- the State and the Federal Government would jointly award a contract to a single contractor to administer the Medicare and Medicaid program on an integrated basis

- the State would contract with the Federal Government who in turn would award a contract to administer both the Medicare and Medicaid programs.

Experimentation would provide the industry lead time in developing the necessary resources in the event of total integration. Potential contractors would need time to change operating systems, including software packages, and hire or train staff. This is important to ensure sufficient competition in the marketplace. Furthermore, it appears that an experiment could be conducted under existing legislative authorities. Sufficient inducements to States such as increased matching, guaranteed cost savings and/or "hold harmless" agreements should be considered in encouraging States to voluntarily participate in any experiments, even though they may require legislation.

B. Contract Uniformity

In addition to the issue of combining the administration of Medicare and Medicaid, another issue which cuts across both programs is the lack of uniformity between the two programs in the award and monitoring of contracts.

At the present time, five different contracts are used in administering the Medicare and Medicaid programs. These include:

- Medicare prime contracts (with intermediaries and carriers)
- Medicare subcontracts (between intermediaries/carriers and other organizations)
- Medicaid contracts (between States and fiscal agents)
- Medicaid subcontracts (between State fiscal agents and other organizations)
- Medicaid Management Information Systems contracts (MMIS).

The substance of these contracts as well as the process for awarding the contracts varies significantly among each contract type. In the case of Medicaid contracts and subcontracts, these variations also occur from State to State. Specific issues concerning the substance and award of contracts include:

- requiring cost/benefit analyses before permitting a contract/subcontract to be pursued
- determining a specific contract life (term)
- allowing extensions beyond the contract period
- requiring a minimum start-up period for phasing in new contracts
- determining the type of evaluation process to be used in making contract awards
- determining the appropriate cost criteria to be used in evaluating proposals.

In addition to differences in the substance and award of each contract, the role played by the Federal Government in the contracting process also varies. Different documents in the contracting process receive prior review and approval, the regional and central offices have varying authorities for prior approval of documents, and the time frames for reviewing and approving documents differ for each program.

Standardization of the Federal Government's role and specific contract elements and processes would promote a more consistent application of policy within the programs, reduce administrative complexity of the contracting function, decrease confusion among potential bidders, and encourage more potential offerors to enter the marketplace.

These contracting issues, however, are too complex and operationally oriented to be fully addressed within the context of this study. Therefore, it is recommended that HCFA carefully explore and examine each issue within the operational context of the Medicare and Medicaid programs and begin to standardize contracts and procedures where appropriate.

C. Data Systems Policy

A third issue included in this study which cuts across both the Medicare and Medicaid programs is data systems policy. The specific issue addressed here concerns the expenditure of Federal dollars for data system development.

Since the inception of the Medicare program, there has been an evolution of methods used to process an increasing volume of Medicare claims. Initially, many contractors relied primarily on processes which required minimal funds for, and application of electronic data processing (EDP) systems. Major technological innovations were adopted by Medicare contractors to enhance their data systems. The Medicare program believed that these changes benefited the program by providing major qualitative and quantitative improvements in Medicare claims processing. These systems changes were reimbursed by the Federal Government under the contractors' cost contracts. Recently, however, the Medicare program has instituted a policy which limits the authorization of capital expenditures for systems development among Medicare contractors. This policy was implemented because given the current state of the art in systems technology, and the possibility of changes in program administration such as regional processing centers or national health insurance, major system changes may not produce the long range cost benefits as they once did and Medicare savings should be realized in the short run.

While Medicare is carefully controlling capital expenditures on systems changes and development, Medicaid is encouraging the expenditures of millions of dollars for new technologies and purchase of software systems. States receive 90% matching for design, development and installation of an MMIS and 75% matching for operation.

Although it appears that Medicare and Medicaid data systems policies may be inconsistent, the purpose for development in both cases, was to improve performance of the individual programs. Medicaid is moving in the same direction as Medicare did, only at a different point in time. It is therefore,

recommended that when Medicaid systems are developed to an adequate level, as currently is the situation with Medicare, developmental funds should be restricted.

D. Competition

A final issue concerning both programs in the contracting arena is that of competition. Competition in the Medicare program is limited to subcontracts and four carrier contracts which were competitively bid under experimental authorities. Currently, no intermediary and 16 carriers subcontract for electronic data processing services (EDP). Subcontracting accounts for 25% of the combined Part A and Part B claims workload and 32% of the Part B only claims workload for FY 1977.

On the Medicaid side, two-thirds of the States contracted with fiscal agents in 1977. These fiscal agent contracts account for approximately 46% of the total Medicaid workload. In the Medicare and Medicaid programs at least a dozen different firms currently hold contracts. Furthermore, in over half the contracts competed, four or more firms submitted bids.

Upon close examination of the data, it was determined that a monopoly did not exist in the data processing field, that there was adequate competition in the marketplace, and that the Medicare and Medicaid programs should continue to improve their contracting procedures to further ensure effective competition for contracts.

APPENDIX 1: STEERING GROUP MEMEBERS

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